

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11150 CERTIFICATE OF DEATH

11143

Reg. Dist. No.

| | | | |
|---|-----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Caroline</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Goldsboro</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Goldsboro</u> | |
| c. LENGTH OF STAY IN TB <u>50 Yrs.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u> | | d. STREET ADDRESS <u>None</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Myra</u> First <u>Fleming</u> Middle <u>Bradley</u> Last | | 4. DATE OF DEATH <u>10</u> Month <u>8</u> Day <u>19</u> Year <u>58</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8/25/1887</u> |
| 9. AGE (In years last birthday) <u>71</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Delaware</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Nathan Fleming</u> | | 14. MOTHER'S MAIDEN NAME <u>No Record</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT Address <u>Rosie B. Smith Goldsboro, Maryland</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-renal Disease</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Sept. 3</u> , 19 <u>57</u> , to <u>Oct. 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct. 8</u> , 19 <u>58</u> , and that death occurred on <u>8:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Greensboro, Md.</u> DATE SIGNED <u>Oct. 11 '58</u> | | | |
| ACTUAL SIGNATURE <u>Charles H. Stonesifer</u> M.D. | | | |
| PHYSICIAN'S NAME (Type) <u>Charles H. Stonesifer, M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>10/11/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Busic</u> | 22d. LOCATION (City, town, or county) (State) <u>Near Barclay, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulais</u> ADDRESS <u>Greensboro, Md.</u> | | 24a. REC'D BY REGISTRAR <u>Oct 15 '58</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanks</u> |

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|------------------------|--|-----------------------|--|--------------------|--|----------------------|--|--------------------|--|--------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF DEATH | | PLACE OF DEATH | |
| JAMES EARL RAY | | 35 | | M | | W | | APR 4 1968 | | MEMPHIS, TENN. | |
| DATE OF BIRTH | | PLACE OF BIRTH | | EDUCATION | | OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | |
| MAY 19 1932 | | MOBILE, ALA. | | HIGH SCHOOL | | ATTORNEY | | HEART DISEASE | | NATURAL | |
| PREVIOUS ILLNESS | | PREVIOUS SURGERY | | PREVIOUS TRAUMA | | PREVIOUS DRUGS | | PREVIOUS ALCOHOL | | PREVIOUS TOBACCO | |
| NONE | | NONE | | NONE | | NONE | | NONE | | NONE | |
| NAME OF PHYSICIAN | | NAME OF HOSPITAL | | NAME OF NURSE | | NAME OF CORONER | | NAME OF JUDGE | | NAME OF CLERK | |
| DR. J. W. WATKINS | | MEMPHIS HOSPITAL | | JANE D. SMITH | | JOHN A. BROWN | | JAMES H. WHITE | | MARY L. GREEN | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF HOSPITAL | | SIGNATURE OF NURSE | | SIGNATURE OF CORONER | | SIGNATURE OF JUDGE | | SIGNATURE OF CLERK | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| DATE | | PLACE | | NAME | | TITLE | | NAME | | TITLE | |
| APR 10 1968 | | MEMPHIS, TENN. | | JAMES H. WHITE | | JUDGE | | JOHN A. BROWN | | CORONER | |

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE COUNTY OF MEMPHIS, TENNESSEE, AND A COPY OF THE SAME IS TO BE FURNISHED TO THE BUREAU OF HEALTH, STATE OF TEXAS.

11151

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Ca roline MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Greensboro | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Greensboro | |
| c. LENGTH OF STAY IN 1b 15 Yrs. | | d. STREET ADDRESS None | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Charles Middle Dennis Last Dennis | | 4. DATE OF DEATH Month 10 Day 19 Year 19 58 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/30/1880 |
| 9. AGE (In years last birthday) 78 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tavern Keeper | | 10b. KIND OF BUSINESS OR INDUSTRY Virginia | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Albert Dennis | | 14. MOTHER'S MAIDEN NAME Sarah Emery | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Anna Dennis | | Address Greensboro, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene of foot 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Peripheral Arterial Disease DUE TO (c) Generalized Arteriosclerosis | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus 260x | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Jan. 15, 1958 , to Oct. 19, 1958 , that I last saw the deceased alive on Oct. 19, 1958 , and that death occurred at 11 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Greensboro, Md. DATE SIGNED 10/22/58 | | | |
| ACTUAL SIGNATURE Charles H. Stonesifer M.D. | | PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 10/23/58 | 22c. NAME OF CEMETERY OR CREMATORY Greensboro | 22d. LOCATION (City, town, or county) (State) Greensboro, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulais | | 24a. REC'D BY REGISTRAR DATE OCT 27 '58 | 24b. REGISTRAR'S SIGNATURE Arthur S. House |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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11152

CERTIFICATE OF DEATH

11145

Reg. Dist. No.

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|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Caroline MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None | | d. STREET ADDRESS None | |
| 3. NAME OF DECEASED (Type or print) First Herman Middle E. Last Euker | | 4. DATE OF DEATH Month 10 Day 28 Year 1958 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/8/1872 |
| 9. AGE (In years last birthday) 86 yrs. | | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Henry Euker | | 14. MOTHER'S MAIDEN NAME Christina Heanrich | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 157-07-0128A | |
| 17. INFORMANT Joseph Simpson | | Address Greensboro, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Disease | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Mar. 10, 1957 , to Oct. 28, 1958 , that I last saw the deceased alive on Oct. 27, 1958 , and that death occurred at 10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Greensboro, Md. DATE SIGNED 10/30/58 | | | |
| ACTUAL SIGNATURE Charles H. Stonesifer M.D. | | PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 10/31/58 | 22c. NAME OF CEMETERY OR CREMATORY Ridgely | 22d. LOCATION (City, town, or county) (State) Ridgely, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. E. Bouleais | | ADDRESS Greensboro, Md. | |
| 24a. REC'D BY REGISTRAR NOV 3 '58 | | 24b. REGISTRAR'S SIGNATURE C. E. H. H. H. | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11152

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

| | | | | | | | | | | | |
|-------------------|--|---------------|--|-----------------------|--|----------------------|--|------------------------|--|------------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES M. BROWN | | 45 | | M | | W | | JAN 15 1880 | | BALTIMORE, MD. | |
| RESIDENCE | | OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | |
| 1234 E. MAIN ST. | | LABORER | | HEART DISEASE | | NATURAL | | JUN 10 1925 | | BALTIMORE, MD. | |
| FATHER'S NAME | | MOTHER'S NAME | | EDUCATION | | RELIGION | | MARITAL STATUS | | SINGLE | |
| JAMES M. BROWN | | MARY J. BROWN | | HIGH SCHOOL | | METHODIST | | MARRIED | | MARRIED | |
| DATE OF INTERVIEW | | INTERVIEWER | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF PHYSICIAN | | SIGNATURE OF REGISTRAR | |
| JUN 10 1925 | | J. M. BROWN | | J. M. BROWN | | J. M. BROWN | | J. M. BROWN | | J. M. BROWN | |

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

11153

CERTIFICATE OF DEATH

Reg. Dist. No.

11146

| | | | | | | | |
|--|----------------------------------|---|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Caroline MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston - Rural | | | | c. LENGTH OF STAY IN 1b Life | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Howard's School | | | | e. STREET ADDRESS Near Howard's School | | | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle Jane Last Haynes | | | | 4. DATE OF DEATH Month October Day 2 Year 19 58 | | | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH November 25, 1871 | | 9. AGE (In years last birthday) 86 yrs. | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Caroline Co., Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William Beulah | | | | 14. MOTHER'S MAIDEN NAME Eliza Horner | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 212-16-7670 | | 17. INFORMANT Mary M. Flamer, Preston, Maryland, R.F.D. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 15 days ? | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from SEPT 18, 19 58 , to OCT 2, 19 58 , that I last saw the deceased alive on OCT 2, 19 58 , and that death occurred at 6:30 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE H.L. Small | | | | ADDRESS (Street, city or town, state) 507 GAY ST. DENTON, MD | | | |
| PHYSICIAN'S NAME (Type) H.L. SMALL MD | | | | DATE SIGNED OCT. 4-58 | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct. 5, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY S aint Paul Cemetery | | 22d. LOCATION (City, town, or county) (State) Near Federalsburg, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland | | | | 24a. REC'D BY REGISTRAR DATE OCT 14 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kane | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11154

CERTIFICATE OF DEATH

Reg. Dist. No.

11147

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Caroline MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston - Rural | | c. LENGTH OF STAY IN 1b Life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Harmony | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston - Rural | |
| 3. NAME OF DECEASED (Type or print) First Florence Middle Emily Last Hicks | | 4. DATE OF DEATH Month October Day 13 Year 19 58 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 12, 1891 |
| 9. AGE (In years last birthday) 67 yrs. | | IF UNDER 1 YEAR: Months 67 Days 13 Hours 19 Min. 58 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (State or foreign country) Caroline County, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME August Kemp | | 14. MOTHER'S MAIDEN NAME Mollie Willoughby | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 219-05-8827 | |
| 17. INFORMANT William Hicks, Jr., Preston, Maryland, R.F.D. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic Heart Disease 8-10 yrs DUE TO (c) Generalized Arteriosclerosis & Left Hemiplegia 3 yrs | | INTERVAL BETWEEN ONSET AND DEATH 15 min | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes mellitus | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4/4 , 19 52 , to 10/12 , 19 58 , that I last saw the deceased alive on 10/12 , 19 58 , and that death occurred at 11 A. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Harold B. Plummer | | ADDRESS (Street, city or town, state) Preston, Maryland | |
| PHYSICIAN'S NAME (Type) Harold B. Plummer, M.D. | | DATE SIGNED 10/15/58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct. 15, 1958 | |
| 22c. NAME OF CEMETERY OR CREMATORY Union Grove Cemetery | | 22d. LOCATION (City, town, or county) (State) Near Preston, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J.J. Framptom and Son, Federalsburg, Maryland | | 24a. REC'D BY REGISTRAR DATE OCT 17 '58 | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11155

CERTIFICATE OF DEATH

11148

Reg. Dist. No.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Ca roline MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Henderson | c. LENGTH OF STAY IN 1b 38 Yrs. | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Rural Henderson | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None | | d. STREET ADDRESS None | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Annie Middle Pably Last g | | 4. DATE OF DEATH Month 10 Day 28 Year 1958 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/7/1881 |
| 9. AGE (In years next birthday) 76 yrs. | | 10. IF UNDER 1 YEAR Months 7 Days 28 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) Germany | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME ? Hoffman | | 14. MOTHER'S MAIDEN NAME No Record | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mary Kibler Henderson, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of iliac artery DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes Mellitus | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct. 18 , 19 58 to Oct. 28 , 19 58 , that I last saw the deceased alive on Oct. 28 , 19 58 , and that death occurred at 9:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Greensboro, Md. DATE SIGNED Oct. 30, 1958 | | | |
| ACTUAL SIGNATURE Charles H. Stonesifer M.D. | | PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/31/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY H oly Cross | | 22d. LOCATION (City, town, or county) (State) Near Greensboro, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boudrais Greensboro, Md. | | ADDRESS | |
| 24a. REC'D BY REGISTRAR NOV 3 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

11118

THE CERTIFICATE

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11156

CERTIFICATE OF DEATH

11149

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Caroline MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg | | | | c. LENGTH OF STAY IN 1b 1 year | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 302 Maple Avenue | | | | d. STREET ADDRESS 302 Maple Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Harry Sharpless | | | | 4. DATE OF DEATH Month Day Year October 26 19 58 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH January 12, 1880 | |
| 9. AGE (In years last birthday) yrs. 78 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist - Sun Shipbuilding Co. | | | | 10b. KIND OF BUSINESS OR INDUSTRY New Bedford, Mass. | | 11. BIRTHPLACE (State or foreign country) U.S.A. | |
| 13. FATHER'S NAME Henry Sharpless | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 195-03-9338 | | 17. INFORMANT Address Mrs. Sara D. Sharpless, Federalsburg, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction 570.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Paralysis Agitans DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 36 hrs. 5 yrs | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 6/1 , 19 55 , to 10/26 , 19 58 , that I last saw the deceased alive on 10/26 , 19 58 , and that death occurred at 8:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Federalsburg, Maryland DATE SIGNED 10-27-58 | | | | | | | |
| ACTUAL SIGNATURE Frank M. Anderson M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) Frank M. Anderson, M.D. | | | | Federalsburg, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct. 28, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery | | 22d. LOCATION (City, town, or county) (State) Federalsburg, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.J. Frampton and Son, Federalsburg, Maryland | | | | 24a. REC'D BY REGISTRAR DATE OCT 28 58 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Thoms | |

11157
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 CERTIFICATE OF DEATH

11150

Reg. Dist. No.

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution) Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Denton</u> | c. LENGTH OF STAY IN 1b <u>life</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Denton</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <u>1</u> | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES ANDREW TAYLOR</u> | | 4. DATE OF DEATH Month <u>Oct.</u> Day <u>4</u> Year <u>1958</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 5, 1882</u> |
| 9. AGE (In years last birthday) <u>76</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Pratt T. Taylor</u> | | 14. MOTHER'S MAIDEN NAME <u>Sallie Dill</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>1</u> | |
| 17. INFORMANT <u>Mrs Charles Taylor, Denton, Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Vascular Renal Disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs -</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>1955</u> to <u>Oct 4</u> , 1958, that I last saw the deceased alive on <u>Oct 3</u> , 1958, and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above. | | | |
| ADDRESS (Street, city or town, state) | | DATE SIGNED | |
| ACTUAL SIGNATURE <u>Dawson O. George</u> M.D. | | <u>Denton, Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>DAWSON O. GEORGE</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <u>Burial</u> | <u>Oct 7, 1958</u> | <u>Denton</u> | <u>Denton, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Jr. Virginia Moore Denton, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>OCT 9 58</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u> |

11158 CERTIFICATE OF DEATH

Reg. Dist. No.

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|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Caroline MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Caroline | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg | | | | c. LENGTH OF STAY IN IB 40 years | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg | | | | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 320 North Main Street | | | |
| d. STREET ADDRESS 320 North Main Street | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First John Middle Smith Last Taylor | | | | 4. DATE OF DEATH Month October Day 5 Year 1958 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH November 29, 1904 | |
| 9. AGE (In years last birthday) 53 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Polishing Room Foreman | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland Plastics | | 11. BIRTHPLACE (State or foreign country) Caroline Co., Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Perry Taylor | | | | 14. MOTHER'S MAIDEN NAME Eva G. Murphy | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 213-03-9736 | | 17. INFORMANT Mrs. Bruce A. Hartzell, Federalsburg, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1 Hepatic Failure 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of Liver DUE TO (c) Malnutrition | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 week 7 Small years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic alcoholism | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 9-8, 1958 , to 10-5, 1958 , that I last saw the deceased alive on 10-5, 1958 , and that death occurred at 4:40 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1107 Tinsmill M.D. 126 Bloomingdale Ave. Federalsburg, Maryland DATE SIGNED 10-6-58 | | | | | | | |
| ACTUAL SIGNATURE H. R. Trapnell | | | | PHYSICIAN'S NAME (Type) H. R. Trapnell, M.D. Federalsburg, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct. 8, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery | | 22d. LOCATION (City, town, or county) (State) Federalsburg, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland | | | | 24a. REC'D BY REGISTRAR DATE OCT 14 58 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Thaw | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11159

CERTIFICATE OF DEATH

11152

Reg. Dist. No.

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|---|---------------------------------|--|--|
| 1. PLACE OF DEATH o. COUNTY Caroline MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Caroline | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ridgely | | c. LENGTH OF STAY IN 1b 53 Yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None | | d. STREET ADDRESS None | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Raymond Middle Thomas Last Thomas | | 4. DATE OF DEATH Month 10 Day 4 Year 1958 | |
| 5. SEX Male | 6. COLOR OR RACE Col. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/1/1905 |
| 9. AGE (In years last birthday) 53 yrs. | | IF UNDER 1 YEAR Months 53 Days 53 Hours 53 Min. 53 | IF UNDER 24 HRS. Months 53 Days 53 Hours 53 Min. 53 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) La boror | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George Thomas | | 14. MOTHER'S MAIDEN NAME Carrie Pritchett | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 213-01-8027 | |
| 17. INFORMANT Viola Thomas Ridgely, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). BRONEHO - PNEUMONIA 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Orchid & bulb ation, Psycho motor seizures 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from June 1953 to Oct 3 1958 , that I last saw the deceased alive on Oct 3 1958 , and that death occurred at 5:15A M, from the causes and on the date stated above. ACTUAL SIGNATURE Charles H Winnacott M.D. ADDRESS Ridgely, Md DATE SIGNED 10/7/58 PHYSICIAN'S NAME (Type) Charles H. Winnacott MD Ridgely, Md 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 10/7/58 22c. NAME OF CEMETERY OR CREMATORY Denton 22d. LOCATION (City, town, or county) (State) Denton, Maryland 23. FUNERAL DIRECTOR'S SIGNATURE J.E. Boules Greenboro, Md ADDRESS 24a. REC'D BY REGISTRAR DATE OCT 8 '58 24b. REGISTRAR'S SIGNATURE William S. Frank | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11160

CERTIFICATE OF DEATH

11153

Reg. Dist. No.

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|--|--|--|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Caroline MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston - Rural | | | | c. LENGTH OF STAY IN 1b 54 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Smithson | | | | d. STREET ADDRESS Near Smithson | | | |
| 3. NAME OF DECEASED (Type or print) First Marie Middle Worm Last Worm | | | | 4. DATE OF DEATH Month October Day 22 Year 19 58 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH March 19, 1868 | |
| 9. AGE (In years last birthday) 90 yrs. | | IF UNDER 1 YEAR Months 0 Days 0 | | IF UNDER 24 HRS. Hours 0 Min. 0 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Austria | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Paul Babor | | | | 14. MOTHER'S MAIDEN NAME Maria Sebesty | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Mrs. Fannie Guidas, Preston, Maryland, RFD | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decomposition DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Right Hemiplegia DUE TO Generalized Arteriosclerosis (c) Generalized Arteriosclerosis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 days 7 days 20 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 10-1-1948 to 10-22-1958 , that I last saw the deceased alive on 10-18-1958 , and that death occurred at 4 A. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Harold B. Plummer | | | | M.D. Preston, Maryland | | DATE SIGNED 10-23-58 | |
| PHYSICIAN'S NAME (Type) Harold B. Plummer, M.D. | | | | Preston, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct. 25, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY Junior Order Cemetery | | 22d. LOCATION (City, town, or county) (State) Near Preston, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J.J. Framptom and Son, Federalsburg, Maryland | | | | ADDRESS J.J. Framptom and Son, Federalsburg, Maryland | | 24a. REC'D BY REGISTRAR OCT 27 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |

11153

CERTIFICATE OF DEATH

11150

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. NAME OF DECEASED <i>John Doe</i> | | 2. SEX <i>Male</i> | | 3. AGE <i>45</i> | | 4. DATE OF DEATH <i>Jan 15 1918</i> | | 5. PLACE OF DEATH <i>Home</i> | |
| 6. OCCUPATION <i>Teacher</i> | | 7. MARITAL STATUS <i>Married</i> | | 8. CAUSE OF DEATH <i>Heart Disease</i> | | 9. MANNER OF DEATH <i>Natural</i> | | 10. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i> | |
| 11. SIGNATURE OF NEXT OF KIN <i>John Doe</i> | | 12. SIGNATURE OF WITNESSES <i>John Doe, Jane Doe</i> | | 13. SIGNATURE OF REGISTRAR <i>John Doe</i> | | 14. SIGNATURE OF CLERK <i>John Doe</i> | | 15. SIGNATURE OF DEPUTY CLERK <i>John Doe</i> | |
| 16. SIGNATURE OF DEPUTY REGISTRAR <i>John Doe</i> | | 17. SIGNATURE OF DEPUTY CLERK <i>John Doe</i> | | 18. SIGNATURE OF DEPUTY DEPUTY CLERK <i>John Doe</i> | | 19. SIGNATURE OF DEPUTY DEPUTY CLERK <i>John Doe</i> | | 20. SIGNATURE OF DEPUTY DEPUTY CLERK <i>John Doe</i> | |
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RECEIVED
JAN 15 1918
BALTIMORE
M.D.